		AND HUMAN SERVICES & MEDICAID SERVICES	45th (day / 10th day	FORM	07/19/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		445191	B. WING _		07/	16/2018
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, HENDERSONVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 370 OLD SHACKLE ISLAND RD HENDERSONVILLE, TN 37075		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	-s	K 00	0		
K 920 SS=D	State of Tennessee Division of Health L Office of Health Car During this life safet was found not in su requirements for pa Medicare/Medicaid Life Safety from fire Protection Associati (2012 Edition) Electrical Equipment CFR(s): NFPA 101 Electrical Equipment Extension Cords Power strips in a pa used for component patient-care-related (PCREE) assemble by qualified personnt 10.2.3.6. Power stri may not be used for electronics), except rooms that do not us PCREE meet UL 13 strips for non-PCRE (outside of vicinity) r care rooms, power s standards. All power precautions. Extens substitute for fixed w Extension cords use immediately upon co which it was installed 10.2.4.	at 42 CFR Subpart 483.70(a), and the related National Fire on (NFPA) standard 101 It - Power Cords and Extens It - Power Cords and Extens It - Power Cords and Extens It - Power Cords and Itient care vicinity are only as of movable electrical equipment at that have been assembled and meet the conditions of ps in the patient care vicinity and non-PCREE (e.g., personal in long-term care resident are PCREE. Power strips for 63A or UL 60601-1. Power in the patient care rooms meet UL 1363. In non-patient strips meet other UL ar strips are used with general sion cords are not used as a	K 92			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

received 8-6-18

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01			COMPLETED	
		445191	B. WING			07/	16/2018
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, HENDERSONVILLE				370	REET ADDRESS, CITY, STATE, ZIP CODE OLD SHACKLE ISLAND RD NDERSONVILLE, TN 37075		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
K 920	This REQUIREMED by: Based on observary maintain the electric The findings included. 1. Observations on 10:57 AM, revealed adapters in the followard at Room 115 b. Room 212 c. Room 301 d. Room 303 (2) e. Room 416(b) f. PT medical recorn NFPA 99, 10.2.4.2 2. Observation on Trevealed an unapple 308. NFPA 99, 10.2.4.2 The maintenance of these deficiencies of the second servariance of these deficiencies of the second servariance of the second second servariance of the second	O) (NFPA 70), TIA 12-5 NT is not met as evidenced tions, the facility failed to cal equipment. ed: 7/16/2018 between 9:00 AM - d extension cords or multiplug owing locations: ds office 2 (2012 Edition) 7/16/2018 at 10:29 AM, roved surge protector in room 2 (2012 Edition) director was present when were identified, and were later he administrator during the exit		920			8/31/18

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN8306

The extension cords or multiplug adapters were removed by Maintenance Director on 7/16/2018 in rooms 115, 212, 301, 303, 416, PT medical records office. The surge protector was removed from room 308 on 7/16/2018. Power strips with a UL rating 1363 or 1363a were placed in rooms 115, 212, 301, 303, 416, PT medical records office, and room 308 on 7/16/2018 by the maintenance director.

Housekeeping Director and Maintenance Director checked every room and office on 7/17/2018 for extension cords, multiplug adapters and unapproved surge protectors and will continue through 8/31/2018 to correct any issues found related to extensions, cords, multiplug adapters and unapproved surge protectors brought in by non-employees.

Information sheets have been added to the center admission packet provided families and patients upon admission of the proper use of UL 1363 and UL 1363A electrical devices.

Maintenance Director and Housekeeping Director will inservice all housekeepers and floor techs by 8/10/2018 on what to observe in a patient's room for extension cords, multiplug adapters and unapproved surge protectors brought in by non-employees and remove immediately and to alert maintenance through the maintenance log book.

Maintenance Director will create a Preventative Maintenance Log indicating a Monthly review of the center to maintain compliance of using the proper electrical extension devices UL 1363 or UL 1363A.

Completion Date: 8/31/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
		445191 B. WING		07/16/2018			
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, HENDERSONVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 370 OLD SHACKLE ISLAND RD HENDERSONVILLE, TN 37075			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG			BE	(X5) COMPLETION DATE
E 000	Initial Comments During the emerge the annual life safet cited.	ency preparedness portion of ty survey, no deficiencies were	E	0000			
_ABORA JO RY	DIRECTOR'S ON PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		↑ TITLE		(X6) NATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.